Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: SAMEER FINO, MD 9850 N. CENTRAL EXPWY #230 DALLAS, TX 75231	MFDR Tracking #: M4-10-1437-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: ""Never received payment."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $770.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: ""Texas Mutual maintains its position as communicated through its EOB."

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
7/28/09	80101	N/A	$720.00	$0.00
7/28/09	80102	N/A	$50.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided after March 1, 2008.
4. 28 Tex. Admin. Code §137.100 applies to the services in dispute.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 09/08/2009

- CAC-197 – Precertification/authorization/notification absent.
- 930 – Pre-authorization required, reimbursement denied.

Explanation of benefits dated 10/20/2009

- CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Issues

1. Did the services the Requestor rendered require pre-authorization from the Respondent?
2. Is the Requestor entitled to reimbursement?

Findings

1. The Requestor billed Current Procedural Terminology (CPT) code 80101 (Drug screen, single drug class method, each drug class) and CPT code 80102 (Drug confirmation, each procedure).
2. The Requestor's appeal letter to the Carrier is reviewed. The Requestor states that "Per TWC Rules, urine drug screens are permitted once every 3 months for patients prescribed pain medication."
3. Pursuant to rule 137.100(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care).
4. Pursuant to rule 137.100(f) A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title. Review of the ODG for July 2009 finds that the services in dispute are not included in the treatment guidelines. Consequently, the services in dispute required preauthorization.
5. For these reasons, the Division finds the billing of CPT codes 80101 and 80102 were not pre-authorized; therefore, no reimbursement is due for these codes.

Conclusion

For the reasons stated above, the division finds that the Requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature	Medical Fee Dispute Resolution Officer	**4/7/2010**
		Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.